Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR SEAN KILGORE DC
2306 S BUCKNER BLVD
DALLAS TX 75227

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name: FLY
Insurance Carrier #:

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-1075-01

MFDR Date Received
October 15, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our position regarding this dispute is that we are entitled to payment for services rendered. The carrier denied payment based on extent of injury. Our notes clearly document that treatment was rendered to the lumbar spine. The lumbar spine is a compensable body area. Compensability was established (agreed to) in the CCH order dated 05-15-2008 [sic] for lumbar disc protrusions. We rendered care that was pre-authorized to the lumbar disc protrusions and have not been paid."

"The majority of services rendered were authorized by Gallagher Bassett's preauthorization department. Since treatment rendered was to the lumbar spine and pre-authorization was obtained prior to rendering the services we feel that the carrier should be ordered to pay according to the guidelines."

"Other services that are required by TDI and that were denied payment due to extent of injury by the carrier are:
A. 99080-73 (TWCC-73) we feel these reports need to be paid because they are a required report according to rule 129.5.
B. 99455-RP (Review of Designated Doctors report) It is our position that this review needs to get paid because according to rule 134.202 the treating doctor is required to review the certification of MMI and assignment of IR by a doctor other than the treating doctor. CPT code with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.00.
C. 99213 This service needs to be paid because evaluation was rendered to the lumbar spine which is a compensable body area."

"Overall, we feel that we are entitled to payment, all services provided need to be paid according to the guidelines."

Amount in Dispute: $7,515.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider seeks payment for treatment that the provider has not shown to be related to the compensable injury. The carrier accepted a low back strain/sprain injury and disputed all other conditions. DWC later determined that the accepted low back strain/sprain injury also included a 2mm protrusion at L5-S1. The ICD-9 codes used by the provider for the DOS at issue include: 722.10 Lumbar intervertebral disc without myelopathy; 724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified; 729.1 Myalia and myositis; 724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified; 729.1 Myalgia and myositis, unspecified; and 353.3 Thoracic root lesions, not elsewhere classified. These are not compensable conditions."

Response Submitted by: Flahive, Ogden & Latson; PO Drawer 13367; Austin TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2008 December 31, 2008	99080-73	$ 30.00	$ 30.00
December 1, 2008	99455-VR	$ 50.00	$ 50.00
December 3, 2008 through December 31, 2008	97110 x 2 units x 10 days 97530 x 2 units x 10 days 97112-59 x 1 unit x 7 days 97112 x 1 unit x 1 day	$844.40 $886.20 $279.30 $ 39.90	$765.60 $809.20 $279.30 $ 39.90
February 2, 2009 March 2, 2009 April 3, 2009 May 1 and 29, 2009	99080-73	$ 75.00	$ 75.00
January 6, 2009 through January 27, 2009	97110 x 2 units x 2 days 97530 x 2 units x 2 days 97112-59 x 1 unit	$168.88 $177.24 $ 43.24	$168.88 $177.24 $ 43.24
January 15, 2009 March 9 and 11, 2009 June 3, 2009	99213	$367.68	$367.68
January 20, 2009 and June 4, 2009	95831 x 2 units x 2 days	$151.16	$151.16
February 2, 2009 through February 25, 2009	97110 x 2 units x 9 days 97530 x 2 units x 8 days 97530 x 1 unit x 1 day	$759.96 $708.96 $ 44.31	$759.96 $708.96 $ 44.31
March 2, 2009 and March 5, 2009	97110 x 2 units x 2 days 97530 x 2 units x 2 days	$168.88 $177.24	$168.88 $177.24
March 12, 2009 and June 8, 2009	97750-FC x 8 units 97750-FC x 12 units	$346.40 $470.00	$ 00.00 $ 00.00
April 7, 2009 to April 30, 2009	97110 x 2 units x 9 days 97530 x 2 units x 6 days 97530 x 1 unit x 2 days	$759.96 $531.72 $ 88.62	$759.96 $531.72 $ 88.62
May 7, 2009 to May 18, 2009	97110 x 2 units x 2 days 97530 x 2 units x 2 days	$168.88 $177.24	$168.88 $177.24
	TOTALS	$7,515.17	$6,542.97

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 relates to MDR – General.

3. 28 Texas Administrative Code §129.5 sets out the requirements for the work status report.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services.
5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific medical services.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 23, 2010 and June 23, 2010

   - 219 - Based on extent of injury
   - 5110 – Service denied per claims examiner's instructions
   - 193 - Original payment decision is being maintained. This claim was processed properly the first time

   Explanation of benefits dated July 6, 2010

   - W4 – No additional reimbursement allowed after review of appeal/reconsideration

Issues

1. Are the disputed services eligible for medical fee dispute resolution according to 28 Texas Administrative Code §133.305 and §133.307?
2. Did the requestor treat the compensable injury?
3. Did the respondent support its denial of "50-these are non-covered services because this is not deemed a 'medical necessity' by the payer."?
4. Is the requestor entitled to reimbursement for all remaining services?

Findings

1. A benefit contested case hearing was held on April 23, 2008 to determine the extent of the compensable injury. The compensable injury is lumbar sprain/strain. Per the Decision and Order issued on May 8, 2008, the hearing officer determined the compensable injury includes a 2 mm disc protrusion at L5-S1 but does not include L4-L5 bilateral radiculopathy or L5-S1 left radiculopathy. Therefore, the extent of injury issue has been resolved and the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.

2. The medical bills and daily notes submitted by the requestor in this dispute were reviewed. The requestor billed a primary diagnosis code of 722.10-displacement lumbar intervertebral disc w/o myelopathy. The Division concludes that the disputed treatment was for the compensable injury.

3. The requestor billed CPT code 99080-73 Work Status Report. The respondent denied this service based upon "50 - these are non-covered services because this is not deemed a 'medical necessity' by the payer."

   Per 28 Texas Administrative Code §129.5, the Work Status Report is a Division specific required report and is reimbursed at $15.00 each.

   Therefore, the denial reason is not supported. The requestor submitted the completed DWC-73 reports in accordance with this rule. Recommend reimbursement of $15.00 x seven days = $105.00.

   The requestor billed CPT code 99455-VR. The respondent denied this service based upon "50-these are non-covered services because this is not deemed a 'medical necessity' by the payer".

   28 Texas Administrative Code §134.204(j) (6) states, "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (6) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor; as stated in the Act and Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier 'VR' to indicate a review of the report only, and shall be reimbursed $50."

   Therefore, the denial reason is not supported. The requestor submitted the completed DWC-069 report to indicate a review of the report only. Recommend reimbursement of $50.00.

4. The remaining services are payable as follows:

- The 2008 physical therapy dates of service are payable per 28 Texas Administrative Code §134.203.

  CPT Code 97110: WC conversion factor $52.83 ÷ Medicare conversion factor $38.087 x participating amount $27.60 = $38.28 x 2 units = $76.56 x 10 days = $765.60.

  CPT code 97530: WC conversion factor $52.83 ÷ Medicare conversion factor $38.087 x participating amount $29.17 = $40.46 x 2 units = $80.92 x 10 days = $809.20.

  CPT code 97112: WC conversion factor $52.83 ÷ Medicare conversion factor $38.087 x participating amount $28.77 = $39.90 x 1 unit x 8 days = $319.20.

- For 2009 physical therapy dates of service are payable per 28 Texas Administrative Code §134.203.

  CPT code 97110: WC conversion factor $53.68 ÷ Medicare conversion factor $36.0666 x participating amount $28.37 = $42.22 x 2 units = $84.44 x 24 days = $2026.56.

  CPT code 97530: WC conversion factor $53.68 ÷ Medicare conversion factor $36.0666 x participating amount $29.77 = $44.31 x 2 units = $88.62 x 20 days = $1772.40

  CPT code 97530: WC conversion factor $53.68 ÷ Medicare conversion factor $36.0666 x participating amount $29.77 = $44.31 x 1 unit x 3 days = $132.93

  CPT code 97112: WC conversion factor $53.68 ÷ Medicare conversion factor $36.0666 x participating amount $29.05 = $43.24 x 1 unit x 1 day = $ 43.24

  CPT code 99213: WC conversion factor $53.68 ÷ Medicare conversion factor $36.0666 x participating amount $61.76 = $91.92 x 4 days = $367.68

  CPT code 95831: WC conversion factor $53.68 ÷ Medicare conversion factor $36.0666 x participating Amount $25.39 = $37.79 x 2 units = $75.58 x 2 days = $151.16

- The requestor billed 97750-FC on two dates of service.

  28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs): Documentation is required. FCEs shall include the following elements:

  (1) A physical examination and neurological evaluation, which include the following:
  (A) appearance (observational and palpation);
  (B) flexibility of the extremity joint or spinal region (usually observational);
  (C) posture and deformities;
  (D) vascular integrity;
  (E) neurological tests to detect sensory deficit;
  (F) myotomal strength to detect gross motor deficit; and
  (G) reflexes to detect neurological reflex symmetry.
  (2) Physical capacity evaluation of the injured area, which includes the following:
  (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
  (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
  (3) Functional abilities tests, which include the following:
  (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
  (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
  (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary

bicycle or treadmill; and
(D) static positional tolerance (observational determination of tolerance for sitting or standing)."

A review of the cardiovascular test portion of both FCE reports documents that a "YMCA 3-Minute Step Test" was used instead of the required stationary bicycle or treadmill test; therefore, all the documentation requirements of §134.204(g) (3) above were not met. No reimbursement can be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports reimbursement sought by the requestor. For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for all disputed services in this dispute, except the FCEs. As a result, the amount ordered is $6,542.97.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,542.97 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		JUNE 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.